

## ADULT PATIENT INFORMATION

(All information will be kept completely confidential)

Address:									Ms.
Name: Mis I prefer to be called: Sex: M Address: City: State									
Address: City: State  Email: Preferred Contact Method  Employer: Bus. Phone:  Employer: Bus. Phone: Bus. Phone:  Employer: Bus. Phone: Bus. Phone:  First Last  Marital Status: Single Married Divorced Separated Widow(er)  If another person will be responsible for payment of this account, please complete the following:  Name: Address: City: State  Zip: Home Phone: Age: Birthdate:  Employer: Bus. Phone:  How did you hear about our Office?  Whom may we thank for your referral?  Please describe your problem and/or concerns:  DENTAL HISTORY  Name of General Dentist: Circle appropriate information)  Frequency of dental checkups: Twice a year / Once a year / only if a problem arises / Never  Date of last cleaning: State appropriate information:  Is there any unfinished care to be completed with your dentist?  No Explain: Do you need Antibiotics for dental visits or cleanings?  No Explain: No Explain: Have you had any Facial or Dental injuries?  No Explain: No Explain: Have you ever had Periodontal (Gum) disease?  No Explain: No Ex	1	M	Sex:		refer to be called:	Ιn			
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Do your gums bleed when you brush?  No	Ye					9		•	
Have you ever consulted an Orthodontist previously?	Ye		No			?	Orthodontist previously?	er consulted an Orth	•
When: Do you feel you have a "gummy" smile? No	Ye		No				my" emile?	zou have a "gummy	
Explain:	10		110				my simic:	ou have a guilling	
Please circle if there is a history of:							orv of:	if there is a history	
Clenching teeth Jaw joint clicking Jaw joint soreness Jaw joint popping Grinding teeth		eth	Grinding tee	w joint popping	soreness Ja	Jaw joint	-	-	
			<i>5</i>			<b>3</b>	<i>, ,</i>		8
Ringing in the ears Frequent Headaches Muscular soreness around head & neck Facial Trauma		•	Facial Trauma	ead & neck Fa	soreness around h	Muscular	Frequent Headaches	n the ears Fi	Ringing in
Speech problems (if so, which sounds)Mouth Breathing while: Awake Asleep			te Asleep	ing while: Awake	Mouth Breath				
Is there any other information that may be helpful?							that may be helpful?	other information that	Is there any otl

Your answers to the following questions will help us with selecting the safest and most effective means of providing your Orthodontic care. All information will be kept strictly confidential.

## **MEDICAL HISTORY**

Physician's Name:				Last Visit:					
Allergic to Latex or Nic Explain:			ry)?				No		Yes
Any change in your gen		Yes							
Explain:Are you currently taking		Vos							
List Drugs:		Yes							
Do you have Osteoporo	No	_	Yes						
Explain: Have you ever taken an	y osteopo	rosis med	lications?				No	_	Yes
List:Are you allergic to any medications?									Yes
							No	_	1 68
List Drugs: Have you ever been told	d not to gi	ve blood	?				No		Yes
Explain: Are you pregnant?							No	_	Yes
Due Date: Have you ever had (or o		l having)	Essial Disstis Cuma	om: of t1		him on iovys?	No		Vac
						nin or jaws <i>:</i> 			Yes
Please circle if you have	e or previ	ously had	any of the following	ng condi	itions:				
Heart Murmur	No	Yes	Hepatitis	No	Yes	Mouth Breather	No	Yes	
Heart Surgery	No	Yes	Diabetes	No	Yes	Frequent Headaches	No	Yes	
Rheumatic Fever	No	Yes	Kidney Disease	No	Yes	Nervous/Anxious	No	Yes	
Endocrine Disorders	No	Yes	Liver Disease	No	Yes	Cancer	No	Yes	
Tuberculosis	No	Yes	Bone Disorders	No	Yes	HIV/AIDS	No	Yes	
Growth Disorders	No	Yes	<b>Blood Disease</b>	No	Yes	Asthma	No	Yes	
Epilepsy	No	Yes	Hives/Rash	No	Yes	Fainting	No	Yes	
Any other health proble	ms or spe	cial conc	erns:						
the patient and the patient from your insurance coinsurance company, classor supplies provided. information will be used above questions. If the Orthodontics of the patient of the patien	ent is respondent.  Important admin  This form dexclusive there are at the above	oonsible f In order istrator and m also and ely for the any futur informat	for payment of fees to do so, please s and consulting health athorizes release of e purpose of evaluate e changes to my tion is correct.	. We wasign belon care performed in the was th	vill prepar low authorofession nformation d adminis	Ill professional services re re necessary forms or reporizing Renjen Orthodontial al information concerning on relating to a claim sub- tering claims for benefits.	orts to help ics to pro health can omitted or I have rea ne Dr. and	you obvide each re, advice your bud and un	tain benefits the respective e, treatment, behalf. This derstand the
Date:									
Primary Insurance Carrier					ıdary Insu	rance Carrier			
Subscriber ID #				Subscriber ID #					
Group ID #									
Social Security/ID #									
Primary Insurance Holder									
Primary Insurance Holder DOB					Secondary Insurance Holder DOB				